Health History Form

Name _____ Personal Physician _____

Emergency Contact Name _____ Emergency Contact Phone # _____

Current Prescription Medications & Dosage _____

Have you ever taken Accutane? Y or N If so, when? _____ Allergies _____

Current Over-the-Counter Medications_____

PATIENT MEDICAL HISTORY (please check the following if apply)

_____**CARDIOVASCULAR** (heart attack, stroke, chest pain, valve disease) _____**RESPIRATORY** (emphysema, asthma, tuberculosis) _____**ENDOCRINE** (diabetes, thyroid) _____**VIRAL** (fever blisters, herpes) _____**INTEGUMENTARY** (psoriasis, eczema) _____**HEMATOLOGIC** (anemia, bleeding tendency) _____**EYES** (glaucoma, cataract) _____**NEUROLOGICAL** (seizures, numbness, tremors)

OTHER (high cholesterol or blood pressure, cancer) _____

Previous Operations & Dates _____

Previous Cosmetic Procedures/ Surgeries & Dates _____

SOCIAL HISTORY

Do you smoke cigarettes ___Y ___N Do you drink alcohol? ___Y ___N

What is your home skin care routine? Please include brand names.

	AM	PM
Cleanser		
Toner		
Topical (Retin-A, Glycolic, Vit. C)		
Moisturizer		
Eyes		
Sunscreen		
Exfoliant, Mask		

Do you experience any of the following?

Face/skin

Puffy Eyes___ Dark circles___ Pigmentation___ Fine Lines___ Unwanted Hair___ Sagging Skin___ Uneven Skin Tone___ Uneven Texture___ Large Pores___ Scars___ Dryness___ Oiliness___ Sensitivity___ Rosacea___ Broken Capillaries___ Other_____

Body

Cellulite___ Spider Veins___ Unwanted Hair___ Unwanted Fat___ Loose Skin___ Stretch Marks___ Scars___ Pigmentation___ Other_____

Check Yes or No:	**YES**	**NO**		**YES**	**NO**		**YES**	**NO**
Have you had a chemical peel?	___	___	Have you had Botox or fillers?	___	___	Have you had laser treatments?	___	___
Do you exercise regularly?	___	___	Are you on a restricted diet?	___	___	Do you have a pacemaker?	___	___
Do you wear contacts?	___	___	Do you have metal implants?	___	___			

I confirm to the best of my knowledge that the answers I have given are correct and that I have not withheld any information that may be relevant to my treatment today.

_____ _____

Patient Signature/Legal Guardian Signature Date